Profile of health in DOWNTOWN TORONTO

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Downtown Health Area
and
The Community Advisory Board

City of Toronto
Department of Public Health

March, 1984

PREFACE

The Downtown Health Area is one of the four Health Areas in the reorganized City of Toronto Department of Public Health. Reorganization occurred in July 1982, with the creation of four Health Areas and a Central Resources Section. As evidenced by the map on the cover, the Downtown Health Area is bounded by Bloor Street on the north, Bathurst Street on the west, the Don River on the east and includes to the south the Toronto Islands.

Several neighbourhoods are situated downtown. Since we often present our health information by census tract, the following list of neighbourhoods includes the census tract in brackets: Donvale (67 & 68); North of St. Jamestown (65); St. Jamestown (65); Homewood (66); Winchester Square (66); South of Carlton (32 & 33); Regent Park (30 & 31); Trefann (30); St. Lawrence (13 & 17); Harbour Square (13); Toronto Islands (2); McGill-Granby (34); North Jarvis (63); Juron-Sussex (61); Spadina-Ulster (60 & 59); Kensington (38); Alexandra Park (39) and South-East Spadina (37 & 36).

Although public health has many important parts, it essentially consists of "collective action to protect and enhance the physical and mental health of a community through preventive rather than curative action" (Public Health in the 1980's).

The Department's total budget was over $21 million in 1983, with about $5 million for the Downtown Health Area. The Downtown Health Area employs 134 people. These include 70 public health nurses, 27 support staff, 23 public health inspectors, 7 dental staff, 2 physicians and 2 community health officers. Each of the four services (Personal Health, Environmental Health and Inspection, Preventive Clinical and Support) reports to a manager. The managers make up an area management team, responsible for coordinating the policies and programs at the Health Area level. The managers are autonomous in their daily activities but responsible to Dr. A.S. Macpherson, the Medical Officer of Health (MOH). All Departmental staff are civic employees and accountable through the MOH to the Local Board of Health.

In an attempt to promote and encourage community participation, the Community Advisory Boards (CAB's) were created in each Health Area. The Downtown CAB include 10 people from the community who provide advice to the Area managers.

Several people provided assistance in the preparation of this report including Marsha Raine,* Community Health Officer; Maurice Moffett, Public Health Inspector; Dr. Richard Fralick, Associate Medical Officer of Health; and the Community Advisory Board. Ian King, Graphic Artist in Central Resources prepared the maps; Voula Karagiannis, Gail Kuwabara and Elizabeth Ginger provided the secretarial assistance. Thank You.

* Principal Author

INTRODUCTION

The Downtown Health Area (DHA) has started the process of determining the health needs of our downtown community then setting priorities, analyzing our present public health programs and developing new programs based on these needs. As well, we have analyzed the existing health information which relates to the DHA. The purpose of this paper is to make you aware of the information that has been gathered so far, relating to the health of the DHA residents and the health needs expressed by the community and staff.

It is our hope that by reading this paper your interest in the health of your community will be increased and stimulated. Your comments and feedback are essential so that we can develop a truly preventive oriented approach to health care, responsive to the needs of the community.

Two documents, about the DHA - the Health Status Report, and The Program Planning Report, provided the information used to compile this report. Here are some highlights.

HIGHLIGHTS FROM THE HEALTH STATUS REPORT, AND THE PROGRAM PLANNING REPORT

DID YOU KNOW THAT ....

- the leading causes of death for both sexes in the DHA include:

    all cancers
    chronic heart disease
    sudden heart attack
    cancer of lung and trachea
    cirrhosis

- liver disease (cirrhosis) among men aged 35 to 64 in the DHA is a leading cause of death and is related to alcoholism;

- suicide is a leading cause of death in the DHA in men aged 15-34 and in women aged 25-39;

- the DHA has the lowest average age of death in the City;

- a large number of Chinese speaking people live in the DHA (9,265) and 33.6% of the City's Chinese population live in this area;

- the number of Portuguese speaking people living in the DHA is 3,410 and 6.8% of the City' s Portuguese population lives in this area;

- 12.7% of the DHA's population are over 65 years of age;

- a large number of neighbourhoods in the DHA have a problem of high unemployment;

- the DHA has the highest rate of teenage (15 to 19 years old) and single mothers, than in other areas of the City;

- the question, "What do you consider to be the five major health issues in the DHA?", was posed to 173 community leaders, professionals and agencies in the DHA to provide community input in priorities and planning programs; - the top ten health problems listed by the DHA community were, in order:

    youth unemployment
    general unemployment
    poverty
    lack of services for ex-psychiatric patients
    social needs of the elderly
    depression
    alcohol abuse
    loneliness
    teenage pregnancy
    isolation in the elderly

- the question posed to the community was also asked to our staff;

- the top ten problems listed by the DHA staff were, in order:

    heart disease
    sexually transmitted diseases
    cancer
    chemical pollution
    communicable disease
    sexually transmitted disease in the gay community
    housing for the elderly
    support and care of the elderly
    smoking
    high risk pregnancy

THE POPULATION CHARACTERISTICS OF DOWNTOWN TORONTO

The DHA has the smallest resident population among the four Health Areas. 92,551 persons or 15.6% of the City's population reside in the DHA. City-wide, the population has decreased by about 100,000 persons over the past 12 years. According to Metro Planning Department assessment data, the City's 1981 population decreased by 1.4% from that in 1980.

AGE & SEX DISTRIBUTION - 1981

Age Group	Population	Males	Females
0- 4	3,665	1,835	1,830
5- 9	3,095	1,595	1,500
10-19	8,930	4,470	4,460
20-34	33,145	17,200	15,945
35-54	19,940	10,995	8,945
55-69	11,390	5,640	5,750
70+	6,870	2,815	4,055

It should be noted that 38% of the DHA population is in the 20-34 years age group. This age group forms the largest percentage of the population in the other three health areas as well. There has been a steady decrease in the under 20 group and an increase in the 35-70 group.

There is a greater number of males (47,633 or 57.5% of DHA population) than females (44,918 or 48.5%), with males having a slight majority in all age groups from 0-19. There is a significant increase in the ratio of males to females in the 20-54 age groups, with the age group 20-34 having the greatest difference. Women outnumber men in the 55-70 age group.The difference is most pronounced in the 70+ group, as females attain greater longevity.

There are a few areas in the DHA with heavy concentrations of the very young and the very old. The neighbourhood represented by census tracts 30 and 31 is a principal area in the DHA with significant numbers of very young children (Map 2). In these two tracts 34.2% or more of the families have children under 19, with 8.7% or more of the families with children under the age of 6. Census tracts 33-35 are areas in the DHA with concentrations of the elderly (Map 2).

ETHNICITY - 1981

Mother Tongue	No. of Persons	% of Population
English	58,010	66.7
Chinese	9,265	10.6
Portuguese	3,410	3.2
French	2,425	2.9
German	1,390	1.6
Italian	880	1.0
Other	11,620	13.4

The DHA has a few areas (census tracts) with high concentrations of mother tongue other than English, although 66.7% of the DHA population has English as their mother tongue. Chinese, Portuguese and French individuals represent 10.6%, 3.2% and 2.9% respectively of the DHA population. 33.6% of the City's Chinese population live in the DHA. Many of these residents are new immigrants. The greatest concentration of Chinese persons in the downtown are found in census tracts 35-39 and 59, while census tracts 38 and 59 have the highest proportion of persons with Portuguese as their mother tongue (Map 3).

Several areas (census tracts 31-33, 63, 65 and 66 - see Map 1) are included among the City's high density areas (10,106.8 persons per square kilometre). This is very important since, when compared with the rest of the City, these are also areas of particularly low socio-economic levels. In fact about half the census tracts in the DHA are areas of the City with the highest concentration of the unemployed (greater than or equal to 8.7% in 1976) (Map 1). Finally there are three census tracts with the highest proportion of the population with less than grade eight education (Map 2).

MAJOR HEALTH ISSUES

Based on the 1981 health information reviewed and the health issues identified by the community and staff, the DHA managers determined certain priority health issues. These seven major health issues are discussed below. You will notice mention of a score such as 7.1, 8.2, etc. These are average scores (so-called Mean answer) out of ten and show the average value given to a particular issue. Further details are in the appendix. We'll begin with Mental Health.

Mental Health

Many factors affect the mental health of the community; millions of tranquillizing drugs are purchased annually and family breakdowns, suicide, violence and crime are alarming increasing trends. The community and staff recognize that mental health problems are ones which need to be tackled by our Health Area and they are, in fact, in agreement as to their relative importance.

There are differences however, in their view of actual health problems within this category. The community expressed the opinion that depression was the most important factor with a rating 8.5; whereas staff felt workrelated stress requires the most attention at 8.1. The staff also felt that depression was important; however, the community felt depression and loneliness were more important. Other problem areas identified by both groups included services relating to mental illness, suicide, general stress and shut ins. (Table 1)

The health information available makes it apparent that illness related to mental health and stress are prime concerns in the DHA. The high rate of suicide among young people in the DHA has placed suicide as the leading cause of death when considering deaths resulting in early loss of life. A high suicide rate among women in the DHA is found in the 25-34 year range and among men in the 15-34 year old range. Cirrhosis, a type of liver disease, can be caused by excessive alcohol consumption which can itself be due to emotional problems. Death rates for liver disease in the DHA are highest in men aged 35-64.

The population characteristics of the DHA suggest a population vulnerable to stress and possibly having difficulty coping with everday pressures. These characteristics include the number of single parent families; the elderly; immigrants; teenage mothers; and those living in high density areas. These groups of people are important target groups for preventive programs to reduce the frequency of mental illness.

Socio-Economic Issues

The report, The Unequal Society: A Challenge to Public Health, examined the link between poverty and ill-health. It considered certain social and economic factors affecting the poor (living conditions, poor access to the health care system, working conditions, etc.) and attempted to show that these factors make the poor more vulnerable to specific health problems and in some cases shorten their life span.

The report suggested that men in higher income brackets live 6 to 7 years longer than those with lower incomes. It also pointed to

specific illnesses such as tuberculosis, influenza, mumps and whooping cough which appear to be more common among the poor.

The community ranked socio-economic issues the top issue with a score of 8.5. Certain problems were identified by the community as important parts of this issue: youth unemployment, general unemployment, poverty and transients. These all received high scores.

Although staff did not rank this issue as a major one (6.5), they did consider two individual problems within this issue, unemployment and disabled people as important, and the issues ranked higher by staff included ones showing the vulnerability of low income groups, e.g., housing for the elderly. This issue and others related to the elderly is covered in a later section.

We have already seen that the downtown population includes individuals living under unfavourable conditions.

The Unequal Society Report stresses that children of low income families in Toronto may be the most vulnerable to inadequate housing and their physical environment. It points to health information on deaths in Canada, that higher death rates occur among children 1-14 years because of income level. These include accidents, poisonings, violence and motor vehicle accidents (involving pedestrians as victims).

Our own health information indicates the specific causes of death for children 14 years of age and under. We know that the leading causes of death in boys aged 5-14 are murder and motor vehicle accidents; for girls 1-4 years of age it is motor vehicle accidents. Unfortunately, we do not have information on the relation between these deaths and socio-economic factors.

Illiteracy and low education are other downtown problems related specifically to the socio-economic issue. In the western portion of the DHA, a significant proportion of the population have less than grade eight education. Our DHA public health nurses and the East End Literacy group (an organization operating in the DHA which assists those who cannot read or write) have suggested that this is a more common problem than the Health Status Report would indicate.

The exact link between socio-economic conditions and ill-health in downtown Toronto has not been proven. It is possible that such a link does exist. We must work toward a better understanding of these factors in order to reduce them.

So Called "Lifestyle Diseases"

In the preface, we defined public health using a definition from Public Health in the 1980's. That report suggested that the majority of deaths in Toronto are attributable to non-communicable diseases such as cancer, heart disease, liver disease, etc. Two methods of contending with these problems were suggested. One method involves an examination of the contributing factors in an individuals' lifestyle, which would tend to increase the risks of developing one of these specific diseases, such as smoking, diet, alcohol abuse, stress and poor physical condition. The other method considers society's responsibility and the pressure it exerts on the individual's lifestyle. This would include a review of the promotion and sale of alcohol and tobacco. It also should consider the role of the workplace in these so-called lifestyle diseases. Technologic change produces increased stress for the individual, perhaps leading to the development of these diseases, and yet the individual worker may have little control over this stress.

The staff indicated a strong interest in this area, with the entire category of lifestyle diseases placing fourth among their main issues. Lifestyle diseases did not rate highly with the community, placing ninth on their overall list of health issues. However, the community did have strong concerns about particular problems within this category. Some overlap with staff (Table I). Heart disease was rated at 7.2 by the community, whereas staff rated it as their top concern with a score of 8.6. Alcohol (8.4) and drug abuse (7.9) were rated as top items by the community, while staff rated cirrhosis, which is related to alcohol abuse, at 7.9. In fact, the most important health issue according to the staff, was substance abuse (alcohol and drugs) (Table II). Other major problems listed by staff included smoking, cancer, lung and respiratory diseases, dental disease, hypertension, atherosclerosis ("hardening of the arteries"), diabetes and obesity. Further major problems listed by the community included drug dealers and lung disease. The community was also concerned about smoking; it received a score of 7.7.

Our 1981 health information indicates the important significance of lifestyle diseases. An examination of the rates of death for both sexes discloses the following causes of death to be among the top ten (not in any order): all cancers (associated with diet and smoking); heart disease (associated with excess cholesterol in the diet, smoking, poorly treated hypertension, stress and poor physical condition); cancer of lung and trachea (also associated with smoking); and cirrhosis (associated with alcohol abuse).

We have listed out the major causes of death in men and women downtown relating to lifestyle diseases, by age group:

CAUSES OF DEATH

AGE	MEN	WOMEN
35-44 yrs.	liver disease* chronic heart disease sudden heart attack	chronic heart disease other digestive problems
45-54 yrs.	sudden heart attack liver disease* suicide	sudden heart attack lung cancer
55-64 yrs.	chronic heart disease sudden heart attack lung cancer	sudden heart attack breast cancer

* cirrhosis is the type of liver disease

Thus the so-called lifestyle diseases are important and significant causes of death in our Area. Both society and the individual must cooperate to reduce the dangers of these health problems. Within the DHA we plan to adjust our current program activities to develop effective education, promotion, and advocacy preventive programs to combat these diseases.

Geriatric Health (The Health of the Elderly)

Based on predictions of the future it is expected that by the year 2001 the proportion of the Ontario population 65 years of age and older will increase from its present 9% to 13%. As advances are made in medical and public health measures, combined with improvements in the standard of living, increased life expectancy can be anticipated.

Clear agreement exists between community and staff that the elderly population in the DHA need assistance. Both rated this the number two health issue. The most pressing needs identified seem to be within the realm of physical, emotional, social, housing and placement needs. The community's major concern was the social needs of the elderly, while the staff listed housing for the elderly as their prime concern. Other health problems listed by both groups in Geriatric Health overlap in many respects. For example social, physical and mental needs of the elderly were cited by the community as areas of high interest. The staff were concerned about support and care of the elderly, placement, crisis intervention, nutritional deficiencies and home care, to list a few (Table I).

The health information for the DHA demonstrates the priority to be given to Geriatric Health. Residents 65 years of age and older

comprise 12.7% of the DHA population (11,754). The DHA had the lowest average age of death in the City of Toronto - 67.3 years; this indicates that the elderly tend to die earlier in the downtown compared to the other areas of the City. The death rate is not, surprisingly, highest in this age bracket. For men 65 and older, the leading causes of death were chronic heart disease, sudden heart attack and lung cancer, while for most women in this age bracket, an additional cause was atherosclerosis affecting circulation to the brain.

Some of these diseases are part of the aging process and their total prevention and control cannot be expected. However, health risks among the elderly can be minimized by encouraging them to practise healthier lifestyles. These include eating nutritiously, avoiding stress, not smoking, exercising regularly and other factors leading to a healthier, longer life.

Based on the health issues, it seems that the health of our elderly may be related to socio-economic factors such as limited income. It is important that effective preventive services are provided for the elderly. We need to continue our efforts on lifestyle diseases, to advocate for improved home support services, day care facilities and suitable housing for the elderly and to encourage the elderly to participate in solving the problems they face.

Environmental Issues

Considerable concern is often expressed about our environment. Real and widespread dangers posed by acid rain, the continuing use of toxic substances in agriculture and pest control, motor vehicle emissions, nuclear power plants and the disposal of nuclear waste and the use of toxic substances in industry are among the major issues.

The four major items related to the environment identified by the community in our survey were cigarette smoke, air pollution, automobile pollution and noise pollution. The staff considered chemical pollution, cockroach and rodent control, water pollution and occupation hazards as important issues. Overall the community did not rank environmental issues as high as staff did (see Tables II and III). Let us consider these various issues.

Cockroaches and rodents are significant problems in multiple occupancy dwellings and food establishments. The public seems to be alarmed about the increasing use of toxic chemicals in controlling such pests. Many persons strenuously object to the use of chemical pesticides in their homes and general environment. The health department is actively pursuing measures aimed at encouraging the use of natural agents in controlling these pests.

Monitoring the bacteriological water quality of the local beaches is a continuous undertaking by our department. Last summer we closed a number of public beaches in the City because of the unusually poor bacterial quality of the water. The health department is currently preparing a detailed report on the quality of Lake Ontario drinking water. This came about because of public concern over chemicals in our water.

Our public health inspectors are being trained and equipped to respond to complaints regarding occupational hazards. This is particularly important because of the increasing use of radiation (as in video display terminals and microwave processing) and the use of toxic chemicals is small industry. We know that there can be an association between certain industrial exposures and the development of cancer.

The community's concern about cigarette smoke was noted earlier in the section on lifestyle diseases. The health department enforces a City by-law regulating smoking in public places and the DHA has conducted programs aimed at soliciting the cooperation of proprietors through "moral suasion". This approach has met with great success downtown.

As already mentioned, the community and the staff expressed concern about air pollution and acid rain. While acid rain poses a serious threat to the ecosystem, this problem goes beyond the scope of the department and the DHA. Positive remedy lies within the realm of provincial, federal and international jurisdictions.

Parent and Child Health

In previous sections we have discussed issues that relate to the health of parents and children. At present a major amount of time is spent by our public health nurses on programs for these two groups. Children are a particularly important focus; we hope that they will learn and develop good attitudes about their health to carry with them throughout their lives.

The community and the staff expressed similar views about parent and child issues. The community was concerned about teenage pregnancies, single parents, poor parenting skills, sex education and birth control counselling. They were also concerned about child abuse. All these issues received a score of 8 or greater. The staff felt that the significant issues were high risk and teenage pregnancies, postnatal problems, high risk parents, child abuse, spouse abuse and poor family supports. These got a score between 7 and 8. Overall the community ranked these various issues as fourth among fourteen (Table III); the staff ranked parent and child issues as eighth (Table II).

We know from our 1981 health information that the number of married women downtown giving birth is lower than that for the City (78% for DHA compared to 86.6% for the City). Single women in the DHA account for a significantly greater number of live births (20.6% for the DHA to 12.4% for the City). As well there are a higher proportion of teenage mothers in the DHA than in the City.

It is quite possible that social and economic factors affect the health of the downtown population. The number of low-income families, a heavy concentration of the unemployed, insufficient and inadequate low-cost housing, the large number of single parent households, high fertility rates among teenage women, poor family supports and isolation all impact upon the health status of the DHA.

Perhaps we need to develop new public health programs targeted towards improving the "living skills" of the young people of the area. Programs concentraing on parenting, nutrition, personal hygiene, household management, etc., could be conducted in DHA schools by qualified staff.

Communicable Diseases - Downtown Health Area

In the past the major priority of public health departments was the prevention and control of communicable diseases. Today these diseases are less common; thus we are moving into the areas of lifestyle diseases and environmental concerns. While the pasturization of milk, water and sewage treatment, sanitary engineering, housing standards, etc. are preventive measures we take for granted, efforts to curb the spread of communicable diseases must remain constant and alert.

It is interesting and somewhat surprising that the community rated communicable diseases as last of the major health issues, since a great proportion of the DHA's collective energies is spent in efforts aimed at mitigating the spread of these diseases (Table III). The major issues identified by the community were incomplete immunization of children, herpes and sexually transmitted diseases (STD's). However, these received a low score of 6 or less. The DHA staff ranked communicable diseases third among the priority health issues (Table II). The important component issues included STD's in general and in the gay community and communicable diseases in general. The staff also felt that tuberculosis (TB) was important. These received a score of 7.5 or higher.

Let us look at the health information for these diseases. The downtown area has a higher number of TB cases than the rest of the City. In 1982 the rate of TB was 53 cases per 100,000 population.

We seem to spend more time monitoring these TB cases since the province's Toronto chest clinic closed in 1982.

The new Immunization of School Pupils Act (1982) makes it compulsory that parents have their children immunized against six communicable diseases - diphtheria, polio, tetanus (lockjaw), measles, mumps and rubella (German measles). As our immunization staff implement this new law we should answer the community's concern about incomplete immunization.

Sexually transmitted diseases (STD's) are important health issues in the entire City and downtown. Although the City's population is about 7% of the Ontario population (in 1977) 38.7% of all reported cases of syphilis occurred in the City. This figure increased to 42.2% in 1980, decreased to 41.1% in 1981, and to 40.2% in 1982. To compare this with gonorrhoea, 23.2% of all reported cases in Ontario in 1977 occurred in the City. This increased to 23.8% in 1981, and declined to 23.6% in 1982. In 1982 there were 1,137 reported cases of gonorrhoea in the downtown. This figure is about 30% of all cases of gonorrhoea reported in the City for all of 1982. Figures for 1982 indicate 408 cases of syphilis in the City. In 1983, there were 228 reported cases of syphilis in the DHA; this was about half of the 1982 cases.

Thus certain communicable diseases are still important. Changing sexual practices resulting in increases of enteric diseases, due to infections in the bowel from bacteria or parasite organisms (e.g., giardiasis, amoebiasis) and the appearance of gonorrhoea bacteria resistant to the usual antibiotics will continue to test the resources and vigilence of the DHA.

Other Issues

Several other issues were raised by both the community and staff, including sexual harrassment (such as rape), needs of the handicapped (the homebound disabled and inadequate transportation) and other inadequacies (such as low cost dental service, education and housing). The scope of these problems will have to be assessed by the DHA to determine the degree to which they fall within our mandate.

WHAT DO YOU THINK? WE'D LIKE TO HEAR FROM YOU.

FUTURE DIRECTIONS

Several important steps are currently underway to continue the planning process and facilitate change in programs where necessary over the next few years.

1. As noted earlier, the DHA is assisted in identifying health problems and in seeking solutions by the Community Advisory Board (CAB). The members include Dan Leckie (Chairman), David Pinkus, Josephine Ciordas, Berdina Johnston, Winnie Ng, Mary Heiberg, Del Wolfson, Toby Vigod, Flora Hesson and Niall Byrne. The public are welcome to attend these CAB meetings and express your perspective on existing health problems. Community participation is an essential part of the service.

   If you have health concerns about your community, you can get together with others in your community to see if they are interested in becoming involved. You can contact the CAB , the DHA managers, or one of the Community Health Officers.

2. The CAB would also like to reach out to the community and obtain feedback regarding the major health issues in the DHA, discussed in this report. They are preparing a series of THEME MEETINGS to involve the community in a discussion of major concerns such as suicide and depression; housing; unemployment, nutrition, and poverty. The first meeting will take place on April 25th at 7:30 p.m. at 519 Church Street and will address the issue of suicide and depression.

   For more information about the Community Advisory Board or the upcoming theme meetings, please call 947-7461.

3. We hope that as a member of our downtown community, you will review this report carefully. We have distributed it to several hundred people in the community including community representatives and leaders and social, recreational and health professionals. It is hoped that this information can then be spread more widely among the downtown community. A pamphlet will go out shortly to several thousand people in the community to encourage their interest in the issues and to familiarize them with the people they can contact on the DHA staff for advice and assistance. Once you have read through the report, please fill out the brief questionnaire on the reverse side of the covering letter and return it to us.

4. The DHA managers and staff have adopted the seven issues discussed in this report as an important focus for our

future public health programs. Before embarking on new programs we plan to carry out a careful evaluation of our existing programs.

This entire process of developing new programs will be carried out in accordance with the newly developed goals of the Department, its legislated mandate as well as the guidelines for the Core Programs included in the new Health Protection and Promotion Act. Even now, many of the services provided by our health inspectors are legally required under The Public Health Act and other laws.

CONCLUSION

Thank you for taking the time to read this report. If you have any questions please call us at 947-7461. As well, we hope you will take part in the upcoming theme meeting and in our Community Advisory Board.

APPENDIX

PLANNING FOR CHANGE

1. The Planning Cycle

Planning is a continuous process, starting with gathering facts and viewpoints; the information collected should lead to specific action being taken.

The following summarizes the steps which have and will be taken by the DHA.

STEP 1 - Presently the DHA is at the beginning of the planning cycle. In fact, planning can best be considered a circular process. Data relating to the population, births, prematurity, sickness and death in the DHA, have been collected and analyzed. Input has been gathered from the community and staff concerning major health problems in the area. The management team in the DHA has reviewed this information in the context of other relevant factors, such as manpower, legal, ethical and financial constraints. It has then been able to identify the major health issues, to assist in assessing current programs and planning new ones.

STEP 2 - Final plans for the DHA must still take into account programs which are recommended by the Department of Public Health as well as the Ontario Ministry of Health. Evaluation which then follows, is an integral part of the planning process. This raises fresh questions and further analysis, leading to continual changes in both objectives and plans. A return to the initial step in the planning process will assist us in obtaining fresh information and viewpoints.

2. The Health Status Report

This report contains a package of information compiled from assessment data (Metro Planning Department), Census Canada and birth and death certificates for 1981. The report permits analysis of health problems in the DHA, identifies trends and patterns of diseases and so assists in program planning.

The section relating to population provides information on the number of people living in the DHA, their sex, age group, the proportion of single and two parent

families, their mother tongue and educational level. These data can point to a need for concentrated work in a particular part of the DHA; or for reaching a segment of the population in a particular way.

A further topic covered by the report is fertility and births. Information is provided in this section on live births and babies born prematurely. The patterns which are observed assist in the planning of family planning, prenatal and postnatal programs.

The final section of the report concerns mortality, showing the deaths caused by specific diseases in 1981. Categorization is made on the basis of age, sex and major cause of death. The number of deaths seen in the DHA is also compared to a larger population - the City as a whole and the province. An examination of the impact of the various causes of death on the years of life lost between ages one and seventy is made. This section helps us focus in on groups of people particularly affected by certain diseases.

It is important to realize that only one year of data is analyzed in this report and interpretation of data from a longer period would be more informative. This report is, however, a first step in data analysis for the DHA and together with community and staff input, provides a firm basis for the evaluation of present programs and planning of new ones.

3. Program Planning Report: Health Issues, Programs & Priorities

As noted in the report, Public Health in the 1980's, input from community and staff is an essential part of the planning process. The opinions obtained from these two groups are outlined in the Program Planning Report, and form a key ingredient in the decision-making process for the DHA. In 1983, community input was requested from a list of 173 selected agencies, professionals and community leaders in the DHA. This list was developed with the assistance of our Community Advisory Board.

An initial questionnaire was mailed out asking the question:

> "What do you consider the five major health problems in the Downtown Health Area?"

From the initial responses, a list of 106 health problems was compiled. We noted that 50% of the

respondents actually lived in the DHA. A second questionnaire was then prepared and sent to the same community people requesting their responses to this list of 106 health problems. The person was asked to rate the health problem on a scale of 1 to 10 (ranging from very unimportant to very important).

The response rate for the second questionnaire was 47% with the highest response coming from women's programs, recreation facilities, correctional and prison groups, and churches. Other groups which responded well were day nurseries, elected representatives, hospitals, multi-cultural groups and centres, community centres, home support services, schools and our Community Advisory Board. A lower response came from accommodation groups, business organizations, community network and advocacy groups, education administrators, information centres and resident/tenant associations.

The responses were tabulated by computer and average scores obtained. The results for some of these are set out in Tables I-III. From the community responses, an average score (mean answer) was recorded for each health problem, reflecting the importance of a problem on a scale of 1-10.

The health problems were further categorized into "major issues", (i.e., alcohol and drug abuse assigned to the lifestyle disease category; unemployment assigned to the socio-economic category). The individual health problem ratings within each major issue category could then be further ranked, as compared to the other categories. For example, "substandard housing", a problem identified by the community received an average score of 6.9 and "overcrowding", another problem identified by the community, received an average score of 6.3. These were the only two components of the major issue of housing which received an overall average score of 6.6 (See Tables I, II and III).

A similar questionnaire was sent to our DHA staff. The response rate was 83%, with a total of 113 major health problems elicited by the initial questionnaire. Of the respondents to the initial questionnaire, 20% were residents of the DHA. An identical tabulation and comparative rating of the responses were completed and are also set out in the three tables.

For purposes of comparison, the following are the listings of the top ten health problems and the average

score of the community and staff (the scores are in brackets):

COMMUNITY	STAFF
Youth Unemployment (8.9)	Heart Disease (8.6)
General Unemployment (8.7)	Sexually Transmitted Disease (STD) (8.5)
Poverty (8.6)	Cancer (8.5)
Lack of Services for Ex-Psychiatric Patients (8.6)	Chemical Pollution (8.3)
Social Needs of Elderly (8.5)	Communicable Disease (8.4)
Depression (8.5)	STD's in Gay Community (8.2)
Alcohol Abuse (8.4)	Housing for the Elderly (8.2)
Loneliness (8.2)	Support & Care of Elderly (8.2)
Teenage Pregnancy (8.2)	Smoking (8.2)
Isolation in Elderly (8.2)	High Risk Pregnancy (8.1)

There are similarities in the health problems identified by the community and staff. High risk pregnancies and teenage pregnancies are seen as important health issues; several health problems affecting senior citizens were identified, including housing, support and care, isolation and social needs.

Other health problems do not appear on the "top ten list" even though high priority is given to them by the community and staff. Unemployment, which rated 8.0, does not appear on the staff list, by reason of its compartively lower ranking to other health problems. Thus both the community and staff consider this to be a major health issue.

Tables II and III provides an overview of the comparative rating of the major health issues given by community and staff.

4. Limitations to the Health Status Report and the Program Planning Report

Certain factors should be considered when reviewing the information in these two reports. The Program Planning Report did not elicit responses from certain groups, whose input might have altered the final analysis. In addition, a 100% response rate would have been desirable, although not realistic. Accordingly, priorities were set with these limitations in mind.

The information provided by the Health Status Report is helpful in providing planning directions although data obtained from three to five years would be far more informative. The interpretation might have to be modified as more data are collected in the next few years.

Morbidity data relating to illness is available only for the City as a whole, for cases of tuberculosis, sexually transmitted diseases and other communicable diseases. The data come from a variety of sources including hospitals, private physicians, laboratories and clinics. We realize that there is considerable underreporting of these diseases. A clear picture of the health status throughout the City of Toronto is therefore difficult to obtain based on the data.

It should also be noted, that certain types of data are not presently available at the community level, such as alcohol and drug intake, cigarette usage and other illnesses. A community health survey was done by the Department of Public Health last year to provide the Health Areas with this type of information and additional data on specific illnesses. Analysis of the information obtained should be available soon.

Evaluation is another area of wide diversity. A need exists to standardize the method of evaluating our public health programs and this topic is being examined in some detail by the department this year. It is anticipated that a more accurate measure of the impact of health programs on our clients can be made.

5. Setting Priorities

Based on the health issues identified and the health information analyzed the DHA managers have set priorities which will assist in changing or maintaining current programs and for which a standardized evaluation mechanism can be developed. These priorities are set out as important health issues in the recommendation section of the Program Planning Report. The priority health issues are:

MENTAL HEALTH

SOCIO-ECONOMIC ISSUES

LIFESTYLE DISEASES

GERIATRIC HEALTH

ENVIRONMENTAL HEALTH

PARENT AND CHILD HEALTH

COMMUNICABLE DISEASES

DO YOU AGREE WITH THESE?

Program	Priority Health Issues, Staff Components of the Program	*Meanans	Priority Health Issues, Community Components of the Program	*Meanans
Mental Health	- Work-Related Stress	8.05	- Depression	8.45
	- Services for Ex-Psychiatric Patients	7.65	- Loneliness	8.22
	- Mental Disorders	7.63	- Stress	8.18
	- Fragmented Mental Health Services	7.62	- Alienation	8.07
	- Suicide	7.50	- Emergencies in the Mentally Ill	7.63
	- Depression	7.45	- Suicide	6.87
	- Early Discharge	7.43	- Insomnia	5.24
	- Shut-Ins	7.07	- Premenstrual Tension	4.89
	- Loneliness	7.00		
	- Lack of Self-Esteem	6.76		
	- Isolation	6.10		
Geriatric Health	- Housing for Elderly	8.16	- Social Needs in Elderly	8.49
	- Support and Care	8.15	- Isolation	8.18
	- Placement	8.06	- Physical Needs	8.16
	- Crisis Intervention	8.00	- Mental Needs	8.06
	- Nutritional Deficiencies	7.94	- Lack of Geriatric Health Maintenance Program	7.90
	- Home Care	7.87	- Confusional States in Elderly	7.27
	- Referral of Elderly to Community Resources	7.94		
	- Homemakers for Elderly	7.81		
	- Shopping Services for Elderly	7.45		
	- Drop In Centres	7.39		
	- Health Educational Programs	6.80		
	- Foot Care	6.39		

* refers to average score - above "7" is significant

Program	Priority Health Issues, Staff Components of the Program	* Meanans	Priority Health Issues, Community Components of the Program	* Meanans
Lifestyle/ Chronic Diseases	- Heart Disease	8.57	- Alcohol Abuse	8.41
	- Cancer	8.50	- Drug Abuse	7.89
	- Smoking	8.15	- Drug Pushers or Dealers	7.57
	- Lung Disease and Respiratory Problems	8.07	- Coronary Heart Disease	7.20
	- Cirrhosis	7.85	- Lung Disease	7.14
	- Dental Disease	7.85	- Hypertension	6.96
	- Hypertension	7.79	- Illness Due to Nutritional Deficiencies	6.72
	- Atherosclerosis	7.66	- Inadequate Physical Activity	6.61
	- Diabetes Mellitus	7.39	- Arthritis	6.51
	- Obesity	7.31	- Emphysema	6.43
	- Arthritis	6.98	- Obesity	6.33
	- Asthma	6.56	- Cirrhosis	6.20
	- Motor Vehicle Accidents	6.30	- Diabetes	6.09
	- Allergies	6.21	- Allergies	6.08
			- Inadequate Rest	5.77
			- Cerebral Palsy	5.65
			- Degenerative Disc Disease	5.62
			- Multiple Sclerosis	5.49
Social/Economic				
	- Unemployment	8.03	- Unemployment - young people	8.94
	- Disabled Persons	7.24	Unemployment - general	8.73
	- Transients - skid row	6.79	- Poverty	8.63
	- Use and Abuse of Women and Minors (Yonge St. Strip)	6.79	- Transients	7.74
	- Recluses	6.55		
	- Poverty	6.25		
	- Poor Personal Hygiene	6.13		
	- Prostitution	6.05		
	- Inability to Budget	5.49		
	- Pornography	5.48		

* refers to average score - above "7" is significant

Source: Program Planning Report

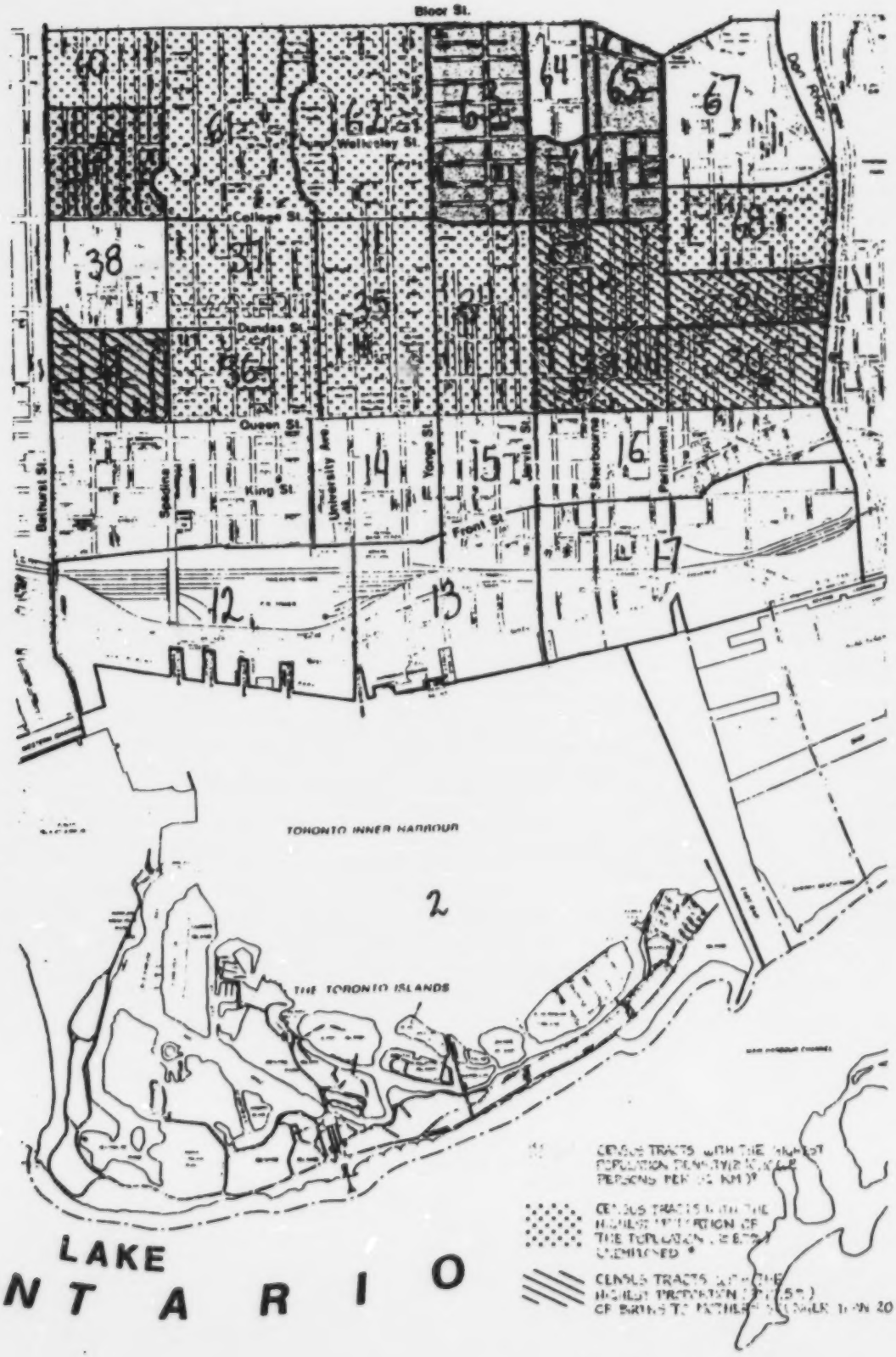
TABLE II

PRIORITY HEALTH ISSUES IDENTIFIED BY THE DHA STAFF

Major Issues	Average Score
Substance Abuse	8.0
Geriatric Health Issues	7.7
Communicable Disease	7.6
Chronic Disease	7.5
Environmental Issues	7.4
Mental Health Problems	7.3
Nutrition	7.1
Parent/Child Health Issues	7.0
Social and Economic Issues	6.5
Inadequate Service	6.5
Housing Issues	6.4
Immigrant Health	6.1
Recreation Facilities	5.4
Inadequate Education	5.3

SOURCE: Program Planning Report

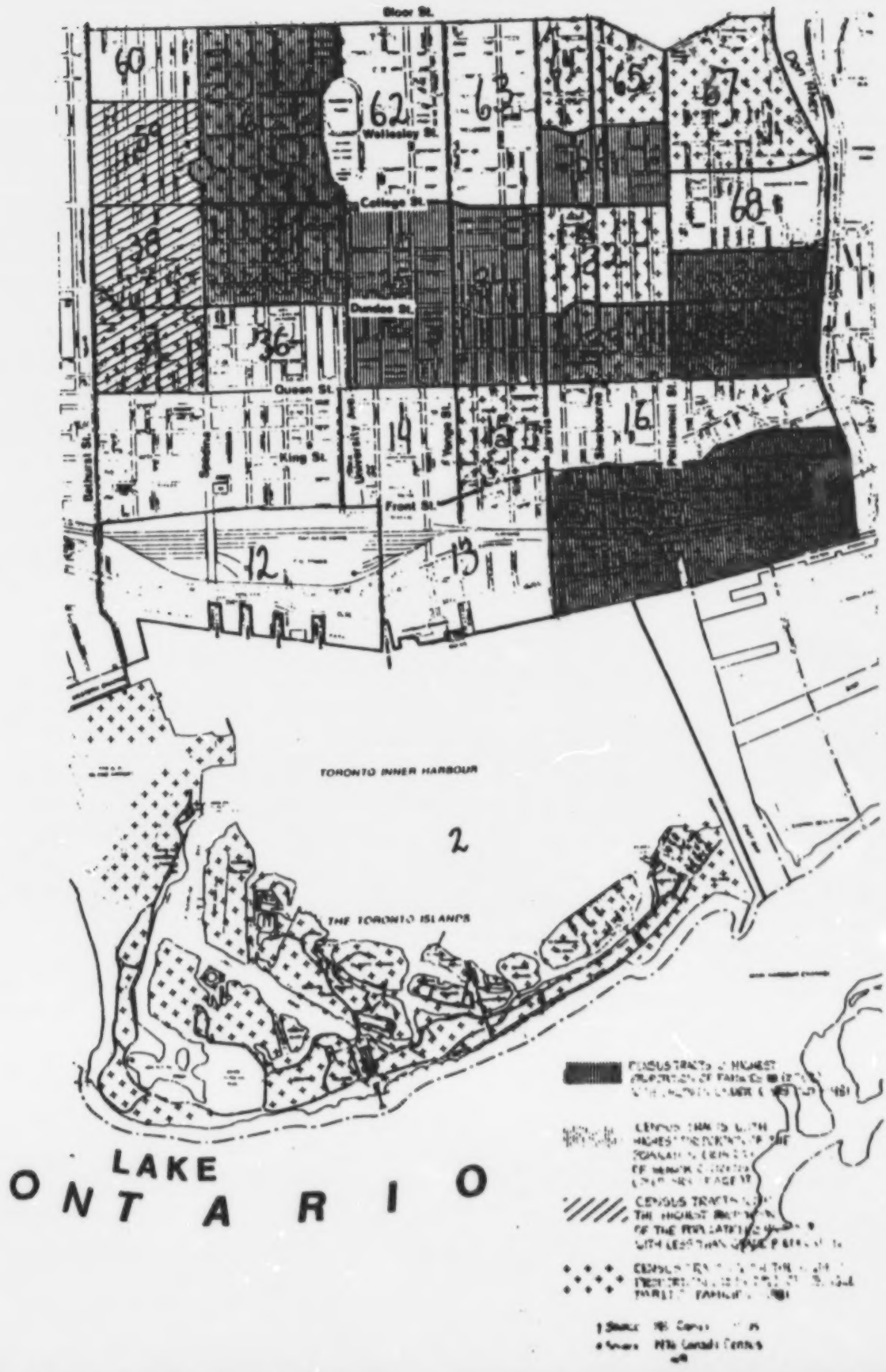
MAP 1



1 Source 1981 Canada Census

4 Source [illegible]

MAP 2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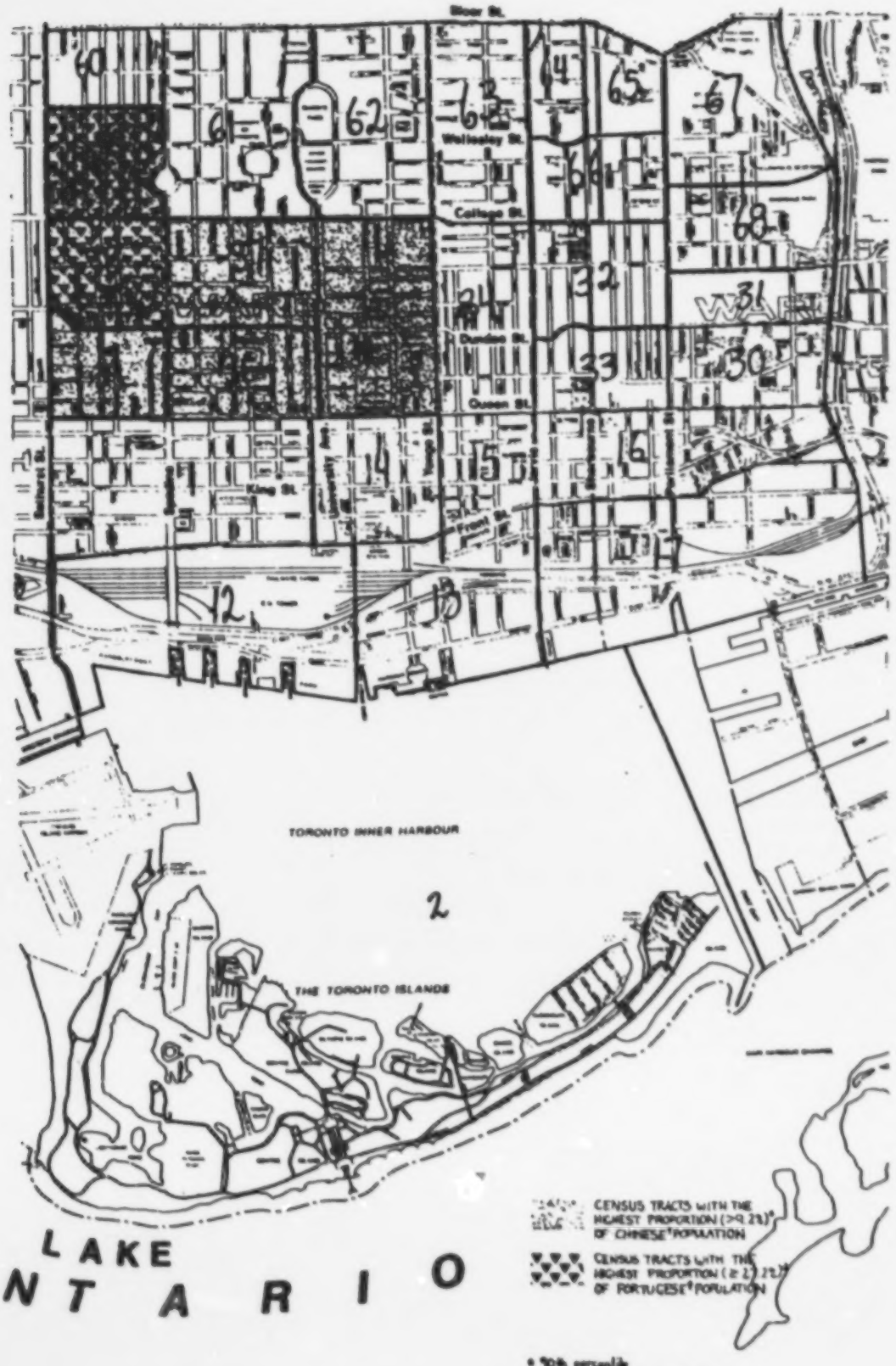
College St.
Dundas St.
Queen St.
King St.
Front St.
Bathurst St.
Spadina
University Ave.
Yonge St.
Wellesley St.
Parliament St.
Don River
60
62
63
65
67
68
59
38
36
14
16
12
13
TORONTO INNER HARBOUR
2
THE TORONTO ISLANDS
LAKE
ONTARIO

MAP 3



* 90th percentile
† Source: 1981 Canada Census

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